

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST Melbourne L Arbin Sr.		2a. DATE OF DEATH MONTH DAY YEAR 12-6-83		2b. HOUR A. 2:30 M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 9-23-1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County MD.	
10. CITY OR TOWN OF DEATH La Plata, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist		12b. KIND OF BUSINESS U.S. Coast Guard	
13a. STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN White Plains		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS Rt. 1 Box 268		13f. ZIP CODE 20695		14. FATHER'S NAME FIRST MIDDLE LAST John W. Arbin		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine M. Rezac	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-28-2253		17. INFORMANT Melbourne L. Arbin Jr.		ADDRESS Rt. 1 Box 268 20695 White Plains, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4920 Cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Respiratory failure DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11-8-83 to 12-6-83, that (I) (we) last saw the deceased alive on 12-5-83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE G.S.R.ATH				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G.S.R.ATH				22e. ADDRESS CHARLES PROFESSIONAL BLDG WALDORF, MD. 20601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-9-83		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME John C. Miller Inc-6415 Belair Rd.-21206				25a. DATE REC'D. BY REGISTRAR DEC 7 1983		25b. REGISTRAR'S SIGNATURE John J. Smith	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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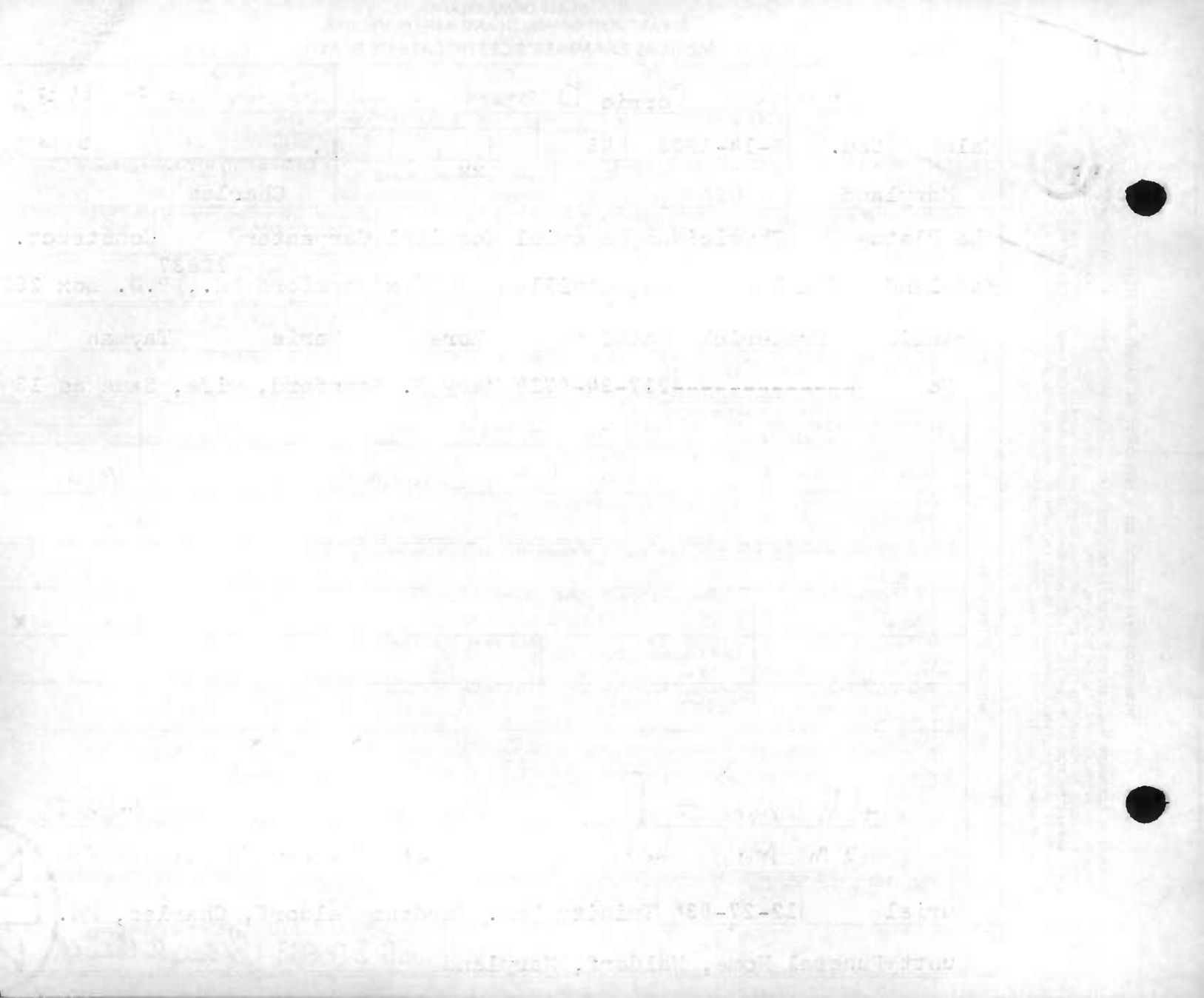
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Charles Perrie Bassford										2a. DATE KNOWN OF DEATH 12-23 1983	
1. SEX Male 4. RACE Cau. 5. DATE OF BIRTH 6-14-1938 6. AGE (IN YEARS) 45 7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.										2b. DATE PRONOUNCED DEAD 12-23 1983	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 11. CITIZEN OF WHAT COUNTRY? USA 12. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter 12b. KIND OF BUSINESS OR INDUSTRY Construct.											
13a. STATE Maryland 13b. CITY OR TOWN Charles 13c. CITY OR TOWN Hughesville 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET ADDRESS 20637 Bassford Rd., P.O. Box 250	
14. FATHER'S NAME (FIRST MIDDLE LAST) Francis Frederick Bassford 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Lora Marie Tayman											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 217-34-0719 17. INFORMANT Mary E. Bassford, wife, Same as 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4140 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) Coronary Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year -	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION N/A 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? N/A 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) 21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE H.M. Mahon-Haft TITLE (SPECIFY) Charles Co M.D. MEDICAL EXAMINER DATE SIGNED 24 Dec 83											
EXAMINER'S NAME (TYPE OR PRINT) H.M. Mahon-Haft MD ADDRESS SR#1 Box 1020, La Plata, Md 20646											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 23b. DATE 12-27-83 23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens 23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.											
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Maryland ADDRESS DEC 29 1983 25a. DATE REC'D. BY REGISTRAR John J. Connel 25b. REGISTRAR'S SIGNATURE											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) AGNES Cooksey DEAN				2a. DATE OF DEATH MONTH DAY YEAR 12-19-83			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 11 10 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Manager		12b. KIND OF BUSINESS OR INDUSTRY Dept. Store	
13a. STATE Md.		13b. COUNTY Chas.		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Edward Cooksey		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Virginia Albrittain		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-24-2700	
17. INFORMANT (dtr) ADDRESS La Plata, Md.		17. INFORMANT (dtr) ADDRESS La Plata, Md.		17. INFORMANT (dtr) ADDRESS La Plata, Md.		17. INFORMANT (dtr) ADDRESS La Plata, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Pulmonary Edema Cardiac Arrest							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE		21h. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 4-6 , 19 76 , to 12-19 , 19 83 , that (1) (we) lost saw the deceased alive on 10-12-83 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Henry L. Burke MD				DEGREE MD		22c. DATE SIGNED 12-19-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Henry L. Burke, Md.				22e. ADDRESS La Plata, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-21-83		23c. NAME OF CEMETERY OR CREMATORY St. Peter's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Huntt Funeral Home Waldorf, Md.				25a. DATE REC'D. BY REGISTRAR DEC 22 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

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30801
Box 287-7, Jackson Drive

Frank Edward Cooksey
Anne "Annie" Cooksey
No. 312-2-2700 Martin Ave. Ocean, N.J. Box 402

Frank Edward Cooksey

Frank Edward Cooksey

Frank Edward Cooksey

Frank Edward Cooksey

Frank Edward Cooksey

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Patricia Bell				2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 12 25 1983				2b. HOUR 6 PM	
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7-23-1948	6. AGE (IN YEARS) (LAST BIRTHDAY) 35 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN		7c. DATE PRONOUNCED DEAD 12 25 1983		7d. HOUR 6 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County			
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Case Worker		12b. KIND OF BUSINESS OR INDUSTRY Social Ser.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE MD		13b. COUNTY Charles		13c. CITY OR TOWN Bryantown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Rt. 5	
14. FATHER'S NAME FIRST MIDDLE LAST Leroy Bell				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Simms					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 215-56-9576		17. INFORMANT 1070 Cedarville Rd Alice Washington Brandywine Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple sharp force injuries 9689 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 1 P.M. 12 25 1983		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject assaulted			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 5 at Hughesville Pond, Hughesville, Charles MD			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 12/27/83	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-29-1983		23c. NAME OF CEMETERY OR CREMATORY St. Marys Ch				23d. LOCATION CITY OR TOWN COUNTY STATE Bryantown Charles MD	
24. FUNERAL DIRECTOR NAME ADDRESS Adams F.H. PA Aquasco Maryland 20608				25a. DATE REC'D. BY REGISTRAR JAN 11 1984		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Baldwin Neale Boone			2a. DATE OF DEATH MONTH DAY YEAR December 23, 1983		2b. HOUR 1:58a M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Feb. 3, 1930	6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.		
10. CITY OR TOWN OF DEATH La Plata 20646	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Computer Sales		12b. KIND OF BUSINESS OR INDUSTRY IBM/RCZ
13a. STATE Maryland		13b. COUNTY Charles	13c. CITY OR TOWN La Plata	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Revell Boone		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Garrett 20646			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1952-55 217-24-0280		17. INFORMANT Rt. # 3, Box 90, La Plata, Md. Maria Teresa Boone-Wife 20646	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> 4860 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mucilobus pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Malnutrition</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____ that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Khadar Baig</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/23/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Khadar Baig, M.D.		22e. ADDRESS Waldorf, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/27/83		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE La Plata, Maryland		23e. DATE REC'D. BY REGISTRAR			
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc.		ADDRESS La Plata, Md.		25a. DATE REC'D. BY REGISTRAR JAN 03 1984	
25b. REGISTRAR'S SIGNATURE John J. Connel					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of and

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Marie L. Bowie				December 19, 1983 4:00 A			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
Female		Caucasian		Sept. 25 1922		61 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Washington, D.C.		U.S.A.				Charles MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
La Plata		Physicians Memorial Hospital		Receptionist		British Embassy	
13a. STATE				13b. CITY OR TOWN		13c. STREET ADDRESS	
Maryland				St. Mary's Mechanicsville		Rte. 2, Box 379 20659	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
James J. Ollerenshaw				Lillian Hardy			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				579-20-2815		Kenneth J. Bowie Rte. 2, Box 379 Mechanicsville, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) Pneumonia							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c) Metastatic NASOPHARYNGEA CANCER							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
Severe Malnutrition							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12/6/83, 1983, to 12/19/83, 1983, that (I) (we) last saw the deceased alive on 12/18/83, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Seetaramayya Nagula, M.D.				MD		12/19/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Seetaramayya Nagula, M.D.				Waldorf, Md. 20601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		12/22/83		Maryland Veterans Cem.		Cheltenham P.G. Maryland	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR		REGISTRAR'S SIGNATURE	
George P. Kalas Funeral Home Oxon Hill, Md.				6160 Oxon Hill Rd. DEC 22 1983		John J. Lankford	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be made.

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DANE William CONNER			2a. DATE OF DEATH MONTH 12 DAY 24 YEAR 83			2b. HOUR 8:30 M	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH 09 DAY 18 YEAR 52		6. AGE (IN YEARS LAST BIRTHDAY) 31 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington D.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY N/A	
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Marbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST Archie MIDDLE William LAST Conner, Jr.		15. MOTHER'S MAIDEN NAME FIRST Fleta MIDDLE Marie LAST Garmen		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-88-3258	
17. INFORMANT FATHER		ADDRESS Box 128, Rt. #484 20658		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Restrictive Lung Disease DUE TO, OR AS A CONSEQUENCE OF (c) Congenital Defects		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Years Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Inappropriate ADIT Syndrome							
19a. DATE OF OPERATION 12/29/83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED ADIT Syndrome		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 10/7 19 83 , to 12/24 19 83 , that (I) <input checked="" type="checkbox"/> saw the deceased give an 11/16 19 83 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> (we) <input checked="" type="checkbox"/> (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE [Signature]		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-27-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Louis V. Kaufman, M.D.		22e. ADDRESS 10905 Ft. Wash. Rd., Ft. Wash., Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-28-83		23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gdns.		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.	
24. FUNERAL DIRECTOR NAME Huntt Funeral Home, Waldorf, Maryland		ADDRESS DEC 29 1983		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE John J. Conner			

BP



William

Charles

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
1- STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

DECEASED NAME (TYPE OR PRINT) Kathleen Mary Cox			2a. DATE OF DEATH MONTH DAY YEAR December 12, 1983		2b. HOUR 1:15 P M
1. SEX Female	4. RACE Cau.	5. DATE OF BIRTH MONTH DAY YEAR 6-17-1887		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Examiner		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Charles 13c. CITY OR TOWN Waldorf			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 916 Sloan Ave., 20601		
14. FATHER'S NAME FIRST MIDDLE LAST John T. Spalding		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Herd			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No (IF YES, GIVE WAR OR DATES) -----		16b. SOCIAL SECURITY NO. 579-60-5467		17. INFORMANT (daughter) ADDRESS Doris C. Scherer, Same as Line 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory failure 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebrovascular Accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-11- 19 75 , to 12-12- 19 83 , that (I) (we) last saw the deceased alive on 12-10- 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (and) (did not) view the body after death.					
22b. SIGNATURE hsnath		DEGREE		22c. DATE SIGNED 12-12-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. G. Shankar Rath, M.D.		22e. ADDRESS #207 Charles Professional Building, Waldorf, Maryland 20601			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-16-1983	23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery Suitland, P.G., Md.		23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Hunt Funeral Home, Waldorf, Maryland		25a. DATE REC'D. BY REGISTRAR DEC 15 1983		25b. REGISTRAR'S SIGNATURE John J. [Signature]	

BP _____

Analysis, Probable, and Intention? (1994)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified within 48 hours.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Mildred Lorraine Della			2a. DATE OF DEATH MONTH DAY YEAR 8 December 15, 1983			2b. HOUR 5:27 a.m.		
3. SEX Female			4. RACE Can.			5. DATE OF BIRTH MONTH DAY YEAR April 06 1929		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 54 YRS.		
10. CITY OR TOWN OF DEATH La Plata			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.		
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Charles La Plata			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS P.O. Box 461 LA PLATA, MD. 20646		
14. FATHER'S NAME FIRST MIDDLE LAST Luther W. Cusic			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily A. Burroughs			12b. KIND OF BUSINESS OR INDUSTRY Own Home		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			16b. SOCIAL SECURITY NO. 217-14-7166			17. INFORMANT ADDRESS John W. Della, Jr. La Plata, Md. 20646		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible Cardiac arrhythmia 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hrs. 12 hrs.							PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Unstable diabetes, type II, insulin dependent.	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9 May 1957 to 15 Dec 1983 , that (I) (we) last saw the deceased alive on 15 Dec 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Arthur Wooddy, M.D.			DEGREE MD			22c. DATE SIGNED 15 Dec 83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur Wooddy, M.D.			22e. ADDRESS La Plata, Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-17-83		23c. NAME OF CEMETERY OR CREMATORY Dentsville Meth. Cen.		23d. LOCATION CITY OR TOWN COUNTY STATE Dentsville Charles Md.	
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc.			ADDRESS La Plata, Md.			25a. DATE REC'D. BY REGISTRAR DEC 19 1983		
			25b. REGISTRAR'S SIGNATURE John J. Casper					

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MARTHA Ophelia EDELEN		2a. DATE OF DEATH MONTH DAY YEAR 12 29 83		2b. HOUR 00:58 AM	
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 01 27 20		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD	
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicans Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife		12b. KIND OF BUSINESS OR INDUSTRY At Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Charles 13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Stonestreet Road Star Route #3, Box 227	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Bradley Baker		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Annie Miles		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	
16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Box 224, Bel Alton, Md. Magdalin Butler-Daughter			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4310 CEREBRAL HEMORRHAGE IMMEDIATE CAUSE (a) 4310 DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION DUE TO, OR AS A CONSEQUENCE OF (c) GASTRO-INTESTINAL CANCER					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-3 hours YEARS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 19 81 , to Dec. 28 , 19 83 , that (I) (we) last saw the deceased alive on Dec. 28 , 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Aurelio C. de la Paz		DEGREE M.D.		22c. DATE SIGNED 12-29-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Aurelio C. de la Paz, M.D.		22e. ADDRESS 128 Rock G, Unit - LA PLATA, M.D. 20646			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/31/83		23c. NAME OF CEMETERY OR CREMATORY St. Mary's Cemetery	
23d. LOCATION CITY OR TOWN COUNTY STATE Newport, Maryland		25a. DATE REC'D. BY REGISTRAR JAN 03 1984			
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc.		ADDRESS - La Plata, Md.			

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or a coroner retained by the hospital or attending physician.

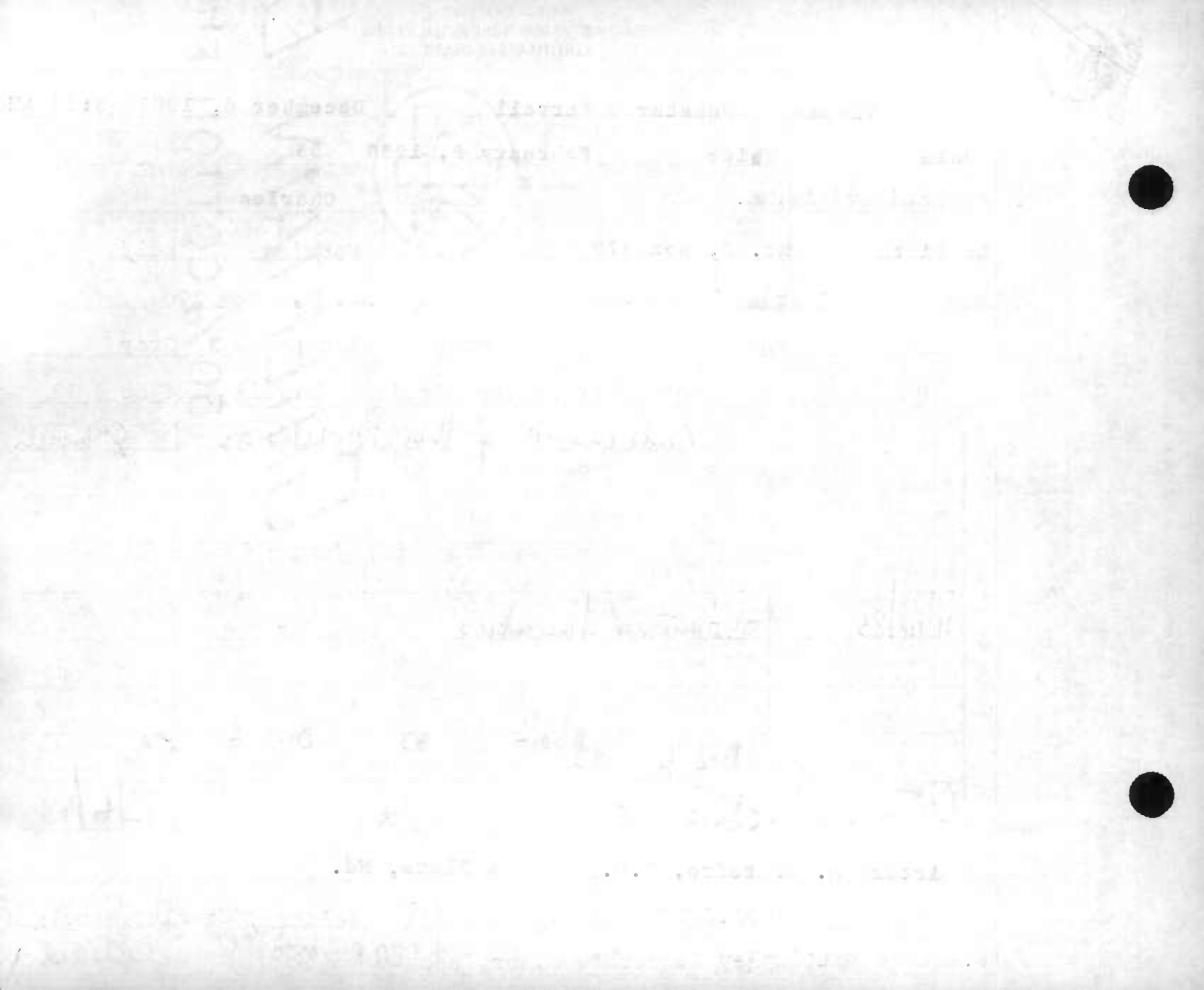
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, then any injury, or other traumatic event, the medical examiner must be notified of once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST				2b. HOUR			
Thomas Webster Farrell				December 6, 1983 3:30 AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN.	
Male		White		February 6, 1930		53 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Mechanicsville, Md.		USA				Charles MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
La Plata		Rt. 5, Box 270		Farming		self	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN	
Maryland				Charles		LaPlata	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Robert Ford Farrell				Agnes Florentine Gray			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) [IF YES, GIVE WAR OR DATES]				16b. SOCIAL SECURITY NO.			
No				217 26 8602			
17. INFORMANT ADDRESS				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:			
Mary Virginia Farrell same as # 13				1579 IMMEDIATE CAUSE (a) Carcinoma of the PANCREAS			
				DUE TO, OR AS A CONSEQUENCE OF (b)			
				DUE TO, OR AS A CONSEQUENCE OF (c)			
				PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
11/16/83		obstructive jaundice		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from April 1983, to Dec. 6, 1983, that (I) (we) last saw the deceased alive on Dec. 6, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
Arturo M. Monteiro, M.D.						1-16/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Arturo M. Monteiro, M.D.				La Plata, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		Dec. 9, 1983		Gardens		Waldorf, Charles, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE			
W. Clarke Mattingley Leonardtown, Maryland				DEC 8 - 1983 John J. Canfield			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified prior to burial.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
JAMES PAUL GODDARD, Sr.			DECEMBER 12, 1983			5:08P M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. YRS.		
MALE	WHITE	9-1-1913	70					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Maryland	USA		CHARLES			Salesman		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
LA PLATA	PHYSICIANS MEMORIAL HOSPITAL		Salesman			Bakery		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS				
Maryland	St. Mary's	Mechanicsville	NO	808 Scott Circle, 20659				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
James Paul Goddard			Mary Estelle Krantz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT (spouse) ADDRESS		
no			578-10-6229			Yolanda Goddard, Same as Line 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF <u>ACUTE-MYOCARDIAL</u> (b) <u>INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 11g								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>12/14/83</u> to <u>12/12/83</u> , that (I) (we) lost saw the deceased alive on <u>12/12/83</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE			DEGREE			22c. DATE SIGNED		
<u>Nallan Ramakrishna</u>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS					
NALLAN RAMAKRISHNA, M.D.			WALDORF, MARYLAND 20601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN, COUNTY, STATE)	
Burial			12-16-83		Gate of Heaven		Silver Spring, Mont., Md.	
24. FUNERAL DIRECTOR					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Hunt Funeral Home, Waldorf, Maryland					DEC 15 1983		<u>John J. G...</u>	

MEDICAL CERTIFICATION

WILLIAM ST. ... 808 ...

... (name) ... same as line 12

CARDIOGENIC SHOCK
ACUTE MYOCARDIAL
INFARCTION

11/12/12 12/12/12 12/12/12

Handwritten signature

... 12-12-88 ...

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Harden Hackley		2a. DATE OF DEATH MONTH DAY YEAR 12 26 83		2b. HOUR 6:25 PM	
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR Jan. 26, 1907	
6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic	
12b. KIND OF BUSINESS OR INDUSTRY Awning Co.		13a. STREET ADDRESS 46 Ell Lane Apt. 46		13b. CITY OR TOWN Waldorf	
13c. STATE Maryland		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 46 Ell Lane Apt. 46	
14. FATHER'S NAME FIRST MIDDLE LAST George A. Hackley		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maude unavailable		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes	
16b. SOCIAL SECURITY NO. Unknown		17. INFORMANT Thelma A. Hackley		17. ADDRESS same as 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 1541 DUE TO, OR AS A CONSEQUENCE OF (b) Renal failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) Carcinoma Rectum with obstructive hepatic					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from February 19 81 to 12-26-1983 , that (I) (we) lost saw the deceased alive on 12-12-1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Girija Rath		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-27-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Girija Rath		22e. ADDRESS Waldorf, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 12-27-83		23c. NAME OF CEMETERY OR CREMATORY Huntt Crematory	
23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.		24. FUNERAL DIRECTOR NAME ADDRESS Huntt Funeral Home, Waldorf, Maryland			
25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE John J. Carver			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3, 4, and 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		83		33254	
1. DECEASED NAME (TYPE OR PRINT) <i>Mary Carolyn Homan</i> <i>Carolyn Homan</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>12-19-83</i>		2b. HOUR <i>8:40 P</i>	
3. SEX Female	4. RACE Cau.	5. DATE OF BIRTH MONTH DAY YEAR <i>Sept. 6, 1900</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>83</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH Bryans Road	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt.#2 Box 192-A		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home
13a. STATE Maryland		13b. COUNTY Charles	13c. CITY OR TOWN Bryans Road	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry H. Aldefer		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine M. Schuyler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 578-50-0193		17. INFORMANT ADDRESS Rt.#5 Box 490-A1 John E. Homan La Plata, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Serious Coronal Vessel Rupture Atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Aging</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hr.</i> <i>years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>None</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>3-5</i> 19 <i>69</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>3-5</i> 19 <i>69</i> to <i>12-19</i> 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>12-16</i> 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Richard H. Dobson</i>		DEGREE <i>M.D.</i>		22c. DATE SIGNED <i>12-19-83</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Richard Dobson, M.D.		22e. ADDRESS Brandywine, Maryland 20613			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-22-83	23c. NAME OF CEMETERY OR CREMATORY Shilo Meth. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Bryans Road, Charles, Md
24. FUNERAL DIRECTOR NAME ADDRESS Huntt Funeral Home, Waldorf, Maryland		25. DATE REC'D BY REGISTRAR DEC 22 1983 REGISTRAR'S SIGNATURE <i>John J. Conner</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										33255 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Mary Louise Jones										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 5 1983	
3 SEX Female		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 1-27-16		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YR. MONTHS DAYS		2b. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 5 1983	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITAITES	
10. CITY OR TOWN OF DEATH Waldorf				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3301 Accokeek Rd				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. STATE MD				13b. COUNTY Charles		13c. CITY OR TOWN Waldorf		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3301 Accokeek Rd	
14. FATHER'S NAME FIRST MIDDLE LAST William Scott				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Belt							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 579-09-5195		17. INFORMANT Faith Jones - Son				ADDRESS SAA	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Diabetes mellitus											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Augusto P. Rodriguez				TITLE (SPECIFY) Deputy				DATE SIGNED 12/5/1983			
EXAMINER'S NAME (TYPE OR PRINT) Augusto P. Rodriguez, M.D.				ADDRESS 5009 Rayburn Ct., Temple Hills, Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12-9-83		23c. NAME OF CEMETERY OR CREMATORY St. Marys		23d. LOCATION CITY OR TOWN COUNTY STATE Piscataway P.6 MD			
24. FUNERAL DIRECTOR NAME Adams F.H. P.A.						ADDRESS Aguaasco Md 20608		25a. DATE REC'D. BY REGISTRAR DEC 15 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

RECEIVED
JAN 10 1953

NAME	ADDRESS	CITY	STATE	ZIP
Mr. J. H. P.	1000 1st St.	San Francisco	CA	94103
Mr. J. H. P.	1000 1st St.	San Francisco	CA	94103
Mr. J. H. P.	1000 1st St.	San Francisco	CA	94103
Mr. J. H. P.	1000 1st St.	San Francisco	CA	94103
Mr. J. H. P.	1000 1st St.	San Francisco	CA	94103
Mr. J. H. P.	1000 1st St.	San Francisco	CA	94103
Mr. J. H. P.	1000 1st St.	San Francisco	CA	94103
Mr. J. H. P.	1000 1st St.	San Francisco	CA	94103
Mr. J. H. P.	1000 1st St.	San Francisco	CA	94103
Mr. J. H. P.	1000 1st St.	San Francisco	CA	94103

RECEIVED
JAN 10 1953

Mr. J. H. P.

1000 1st St.

San Francisco

CA

94103

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Johnson William Jones				December 20, 1983			
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR Jan. 27, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) #1 Colebrook Dr. Rt. 4 Box 4190		12a. USUAL OCCUPATION (OF WORK FOR MOST OF WORKING LIFE) Electrical work		12b. KIND OF BUSINESS OR INDUSTRY Construction	
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Jones		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alberta Farrell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 217-14-7462		17. INFORMANT ADDRESS Patricia Ann Jones same as 13		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>infection</u> 1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic colon cancer</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (I) (this hospital) attended the deceased from <u>10/27</u> , 19 <u>82</u> , to <u>11/28</u> , 19 <u>83</u> , that (I) (we) lost <u>saw the deceased alive above (I we did not)</u> view the body after death.			
22b. SIGNATURE <u>D. J. Haidak</u>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-21-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. J. HAIDAK M.D.		22e. ADDRESS 7801 Old Branch Avenue Clinton, Maryland 20735		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			
23b. DATE 12-22-83		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE La Plata, Charles, Md.		24. FUNERAL DIRECTOR Hunt Funeral Home, Waldorf, Maryland	
25a. DATE REC'D. BY REGISTRAR DEC 23 1983		25b. REGISTRAR'S SIGNATURE <u>Sam J. Laniel</u>					

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the health department. Page 4 may be retained by the funeral director.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Baby Boy Kohl				2a. DATE OF DEATH MONTH DAY YEAR 11-12-83			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 11-12-83		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 8 8	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Columbia Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MD.	
10. CITY OR TOWN OF DEATH Baltimore, Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None	
13a. STATE Maryland				13b. COUNTY -		13c. CITY OR TOWN Washington, D.C.	
14. FATHER'S NAME FIRST MIDDLE LAST Ron Reese				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Frances Kohl			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. No		17. INFORMANT ADDRESS Frances Kohl			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 7650 IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Extreme Prematurity</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 hours							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) P.M. 19		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/12, 1983, to 11/12, 1983, that (I) (we) lost saw the deceased alive on 11/12, 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Charles Kohl				DEGREE MD		DATE SIGNED 11/12/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Kohl				22c. ADDRESS St. Agnes Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/14/84		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Leroy M. & Russell C. Witzke Funeral Homes P.A.				25a. DATE REC'D. BY REGISTRAR FEB 14 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	
1630 Edmondson Avenue, Catonsville, Md. 21228							

3

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5-6. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST Thomas			MIDDLE Benjamin			LAST Maddox			2a. DATE KNOWN OF DEATH ESTIMATED			MONTH 12			DAY 25			YEAR 1983			2b. HOUR M		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 8, 1961		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD			MONTH 12			DAY 25			YEAR 1983			2d. HOUR 11:15 P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Charles County, MD.														
10. CITY OR TOWN OF DEATH La Plata				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None				12b. KIND OF BUSINESS OR INDUSTRY N/A														
13a. STATE Maryland				13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 20646 207 West Hawthorne Drive																
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Fredrick Maddox								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shirley Ann Newcomb 20646																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-88-7040				17. INFORMANT P.O. BOX ADDRESS, La Plata, Md. Thomas Fredrick Maddox-Father																		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shotgun wound of mouth</u> 9551 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF																		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?														20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR AM MONTH DAY YEAR 7:20 P.M. 12 25 1983				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Self inflicted																		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 207 W. Hawthorne Dr., La Plata, Charles, Md.																		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion																										
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER														DATE SIGNED 12/27/83								
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 11 Penn St. Balto., MD.																						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/27/83				23c. NAME OF CEMETERY OR CREMATORY Mount Rest Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE La Plata, Charles, Md.														
24. FUNERAL DIRECTOR NAME Arenhart Funeral Home, Inc. - La Plata, Md.																		25a. DATE REC'D. BY REGISTRAR JAN 03 1984		25b. REGISTRAR'S SIGNATURE <i>John J. Lohr</i>						

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGE 2 AND 5 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DMMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		Nancy		MIDDLE		Milligan		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		Nancy		Viola		Milligan		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH DAY YEAR		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR.		8. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
F		W		2-19-29		54 YRS.		MONTHS		DAYS		HOURS		MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		WIDOWED		DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.	
Virginia		U.S.A.										Charles			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
La Plata		Physicians Mem. Hospital		Homemaker		Own Home									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Fla.		Marion		Citra		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rt. #4 Box 3555		32627					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
FIRST MIDDLE LAST		FIRST MIDDLE LAST													
Joseph Thomas Harris		Alma Estelle Hudson													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT											
NO		228-26-1067		Neil S. Milligan same as 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
4140		cardiac arrest				coronary artery disease		years							
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?											
NIA				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION											
				STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED							
H.M. Mahan-Haft		Charles						28 Dec 83							
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS													
H.M. Mahan-Haft		SR#1 Box 1020 La Plata Md 20646													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE					
Burial		1-3-84		Forest Lawn Cemetery		Ucala, Marion, Fla.									
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
Huntt Funeral Home,		Waldorf, Maryland		DEC 30 1983		John J. Connelley									

7999999

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

33260

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nick N/M/N Rezar			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 12 1 1983			2b. HOUR 8:49 PM		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 27 21	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 62	IF UNDER 24 YRS. MONTHS DAYS HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 12 1 1983			2d. HOUR 8:49 PM
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles		
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Examiner		12b. KIND OF BUSINESS OR INDUSTRY D.A.V.	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Charles 13c. CITY OR TOWN Waldorf				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2342 Mail Coach Court		
14. FATHER'S NAME FIRST MIDDLE LAST George Rezar				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Fertish				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes Yes		(IF YES, GIVE WAR OR DATES) WW II		16b. SOCIAL SECURITY NO. 578-2197		17. INFORMANT ADDRESS Wife's chart Wilma W. Rezar same as 13		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) coronary artery disease (c) chronic pulmonary disease								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years 1 year
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION MA			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? MA				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE H.M. Mahan-Haft			FILE (SPECIFY) M.D. Charles			MEDICAL EXAMINER		DATE SIGNED 2 Dec 83
EXAMINER'S NAME (TYPE OR PRINT) H.M. Mahan-Haft			ADDRESS S.R.#1 Box 1020 La Plata Md 20646					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-5-83		23c. NAME OF CEMETERY OR CREMATORY Md. Vet. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham, P.G. Md.		
24. FUNERAL DIRECTOR ADDRESS Muntt Funeral Home, Waldorf, Maryland				25. DATE REC'D. BY REGISTRAR DEC 5 1983		25. REGISTRAR'S SIGNATURE John J. Carver		

U.S. V.

19801

2000 Mail Drop Court

Section

Julia

Barry

George

11-11-80 11:00 AM

11-11-80

11-11-80

11-11-80

11-11-80 11:00 AM

11-11-80 11:00 AM

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Elmer Monroe Sampson			2a. DATE OF DEATH MONTH DAY YEAR 12 25 83			2b. HOUR 4:30 P_M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 18th, 1903^R		6. AGE (IN YEARS LAST BIRTHDAY) 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Installer	
12b. KIND OF BUSINESS OR INDUSTRY Telephone Co.		13a. STATE Maryland		13b. COUNTY Prince Geo.		13c. CITY OR TOWN Newburg	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS P.O. Box 35		13f. POSTAL ADDRESS 20664			
4. FATHER'S NAME FIRST MIDDLE LAST Frank M. Sampson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Utz				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 577 01 2093		17. INFORMANT ADDRESS Mary E. Sampson Same as #13 (Wife)		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4149 IMMEDIATE CAUSE (a) Cardiopulmonary arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Coronary Heart Disease.
DUE TO, OR AS A CONSEQUENCE OF
(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.

Emphysema

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>May</u> , 19 <u>80</u> , to <u>12-25</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>11-28</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE <u>G. Rath</u>				DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/27/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. G. Rath				22e. ADDRESS Waldorf, MD			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/29/83		23c. NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		23d. LOCATION (CITY OR TOWN) COUNTY STATE Brentwood P.G. Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certificate completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) NOEL THADDEUS SIMMONS					2a. DATE OF DEATH MONTH DAY YEAR December 18, 1983					2b. HOUR 7:00pM
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Oct. 2, 1889		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U. S. of A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CHARLES COUNTY MD.				
10. CITY OR TOWN OF DEATH LA PLATA		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PHYSICIANS MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Powdr. Fac. Att.		12b. KIND OF BUSINESS OR INDUSTRY U.S.N.O.S.		
13a. STATE Maryland					13b. COUNTY Charles		13c. CITY OR TOWN Indian Head		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Noel Roney Simmons					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida De Lozier					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 214-36-2902		17. INFORMANT ADDRESS Inez Henley-Niece Marbury, Md. 20658			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio pulmonary arrest 4273 DUE TO, OR AS A CONSEQUENCE OF (b) Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Papillary mitral fibrillation PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Sepsis and mitral fibrillation APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Sepsis and mitral fibrillation										
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Michael Leatherwood, MD					22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22d. DATE SIGNED 12/19/83
22e. PHYSICIAN'S NAME (TYPE OR PRINT) MICHAEL LEATHERWOOD, M.D.					22f. ADDRESS WALDORD, MARYLAND 20601					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/22/83		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Suitland P.G. Md.			
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc., LaPlata, Md.					25a. DATE REC'D. BY REGISTRAR DEC 28 1983					25b. REGISTRAR'S SIGNATURE John J. Connelley

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and one of the following must be completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Margaret SNELL				2a. DATE OF DEATH MONTH DAY YEAR 12-22 83		2b. HOUR 10⁵⁰ AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 06 01 91		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 92	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Mem. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Charles		13c. CITY OR TOWN Indian Head	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Kavanaugh				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Wilson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 219-34-7679		17. INFORMANT ADDRESS Diana L. Falls Rt. #1 Box 282 Lyndhurst, Va. 22952			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Atherosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Diabetes Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12-21 , 19 83 , to 12-22 , 19 83 , that (I) (we) lost 12-21 above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Henry L. Burke MD				DEGREE MD		22c. DATE SIGNED 12-22-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Henry L. Burke, M. D.				22e. ADDRESS La Plata, Maryland			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-24-83		23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf, Charles, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Huntt Funeral Home, Waldorf, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

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Page of 1

Charles

Physician (Mr. Hospital) x 15 Greenwood Ave. 2024

John, New York, 11101
----- 218-24-708 Diana L. Laie Lyndale, N. 2222
P.O. Box 282

x

12-24-83 Trinity Non-Baptist Church, Charles, Mo.
17. Henry L. Burke, N. D. La. 11101, New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Alice Roach Snyder			2. DATE OF DEATH MONTH DAY YEAR December 29, 1983			2b. HOUR 10:45 M	
3. SEX Female		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 07/24/34		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.	
7a. BIRTHPLACE Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH Port Tobacco		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary/ Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Port Tobacco		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST EVERETT FRANK ROACH		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN SEARS ROACH		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b. SOCIAL SECURITY NO. 229-42-2181		17. INFORMANT ADDRESS Mr. Curtis D. Snyder-Husband 20677 Route #1, Box 1137B1, Port Tobacco, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible respiratory collapse DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic adenocarcinoma to lungs DUE TO, OR AS A CONSEQUENCE OF (c) Adenocarcinoma breast Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 1749							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: None							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 24 19 83 , to Dec 29 19 83 , that (I) (we) last saw the deceased alive on Dec 29 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Arthur O. Wooddy MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 29 Dec 83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR O. WOODDY, MD		22e. ADDRESS Box 430 LA PLATA, MD 20646					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 1/3/84		23c. NAME OF CEMETERY OR CREMATORY Sherwood Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Salem, Virginia	
24. FUNERAL HOME NAME ADDRESS John M. Oakley Funeral Home, Inc., La Plata, Md. John M. Oakley Funeral Home, Salem, Va.							
JAN 03 1984				John J. Church			



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Joseph Leon Summers, Sr.				2a. DATE OF DEATH MONTH DAY YEAR December 12, 1983			
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 10-9-1895		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Gen'l Store	
13a. STATE Maryland				13b. COUNTY Charles		13c. CITY OR TOWN Waldorf,	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Alton Summers				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Rosalie Burch			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW1		17. INFORMANT (spouse) ADDRESS Caroline Summers, Same as line 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest 4960 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic obstructive lung disease. DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-8-1980 to 12-12-1983 , that (I) was last saw the deceased alive on 12-10-1983 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) certified (did not) view the body after death.							
22b. SIGNATURE G. Shankar Rath				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-12-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. Shankar Rath M.D.				22e. ADDRESS #207 Charles Prof. Cen. Waldorf, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-14-83		23c. NAME OF CEMETERY OR CREMATORY Old Fields Church		23d. LOCATION CITY OR TOWN COUNTY STATE Hughesville, Charles, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Huntt Funeral Home, Waldorf, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 15 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

BP

Number, 12, December 12, 1953 9:00

10-1-1953 108

108

108

108

108

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12-12-53

x

12-12-53

12-12-53

12-12-53

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth Pearl Thompson				MONTH DAY YEAR 12 5 83		2b. HOUR 2:16am	
3. SEX Female		4. RACE American Indian		5. DATE OF BIRTH MONTH DAY YEAR 1 7 50		6. AGE (IN YEARS LAST BIRTHDAY) 33 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Charles		13c. CITY OR TOWN Pisgah		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> XX	
14. FATHER'S NAME FIRST MIDDLE LAST William G. Thompson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Aline Proctor		13e. STREET ADDRESS General Delivery			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-74-2089		17. INFORMANT ADDRESS William G. Thompson same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic Cancer of Breast DUE TO, OR AS A CONSEQUENCE OF (c) 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
20. I certify that (I) (this hospital) attended the deceased from 11/29/83 19 83 , to 12/5/83 19 83 , that (I) (we) last saw the deceased alive on 12/31/83 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE 		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Khadar Baig, M.D.		22e. ADDRESS La Plata, MD 20646					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-9-83		23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Chapel Point Chas. Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Arehart Funeral Home, Inc. La Plata, Md.				25a. DATE RECD. BY REGISTRAR REGISTRAR'S SIGNATURE DEC 9 8 1983			

BP _____



Female

American
Indian

33

x

U.S.A.

Maryland

Home

2064

General Delivery

Charles

Proctor

Alina

Mary

Thompson

G.

William

242-74-20 William G. Thompson same as 13

Bureau of Census and Statistics
Archaeological Home, Inc. La Plata, Md.
St. Ignace Cemetery, Chapel Point, Ches. Md.
12-7-73

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at _____

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) Samuel SevSrino Vacchiano					2a. DATE OF DEATH MONTH DAY YEAR December 6, 1983			2b. HOUR 6:01a	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Nov. 22, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U. S. of A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.			
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Businessman		12b. KIND OF BUSINESS OR INDUSTRY Self-Employed	
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN La Plata		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 101 Maple Ave. Zip: 20646	
14. FATHER'S NAME FIRST MIDDLE LAST Aniello Frank Vacchiano				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Angela Maria Alfieri					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes W.W.II				16b. SOCIAL SECURITY NO. 217-34-0356		17. INFORMANT ADDRESS Jeanette Carnevale Florence, N.J.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac Arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 minutes									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a Diabetes Mellitus									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Dec 3, 1983 to Dec 6, 1983 , that (I) (we) lost saw the deceased alive on Dec 6, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Arturo Monteiro, M.D.				DEGREE M.D.				22c. DATE SIGNED 12/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arturo Monteiro, M.D.				22e. ADDRESS La Plata, Md. 20646					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/10/83		23c. NAME OF CEMETERY OR CREMATORY Sacred Heart		23d. LOCATION CITY OR TOWN COUNTY STATE La Plata Charles Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Arehart Funeral Home, Inc., LaPlata, Md.						25a. DATE REC'D. BY REGISTRAR DEC 12 1983			
25b. REGISTRAR'S SIGNATURE John J. Carney									

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) Homer Thornton Vaughan		December 21, 1983		7:18 P.M.	
3. SEX Male	4. RACE Cau.	5. DATE OF BIRTH 09/30/14		6. AGE (IN YEARS LAST BIRTHDAY) 69.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH La Plata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physicians Memorial Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
12a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12b. STATE Maryland		13a. CITY OR TOWN La Plata		13b. STREET ADDRESS P.O. Box 384 Zip: 20646	
14. FATHER'S NAME FIRST MIDDLE LAST Willis A. Vaughan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Blanche Sellers		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) YES WWII	
16b. SOCIAL SECURITY NO. 409-03-1632		17. INFORMANT ADDRESS Elizabeth Vaughan same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Irreversible Respiratory Collapse. 2028 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Esophageal hemorrhage. DUE TO, OR AS A CONSEQUENCE OF (c) Lymphoma with mediastinal mass.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min. 24 hrs. 4 years.
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21e. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. DATE SIGNED 21 Dec 83	
22a. SIGNATURE Arthur O. Woody MD		22b. ADDRESS La Plata, Md		22c. DATE SIGNED 21 Dec 83	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-23-83		23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Garden	
24. FUNERAL DIRECTOR NAME Arehart Funeral Home, Inc.		24b. ADDRESS La Plata, Md.		25. DATE REC'D. BY REGISTRAR DEC 28 1983	

100% COTTON

CHIEF



United Fruit Company, Inc., 1000 N. 1st St., Miami, Fla.

100-100-100

100-100-100

100-100-100

3

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death and returned by the hospital or attending physician.

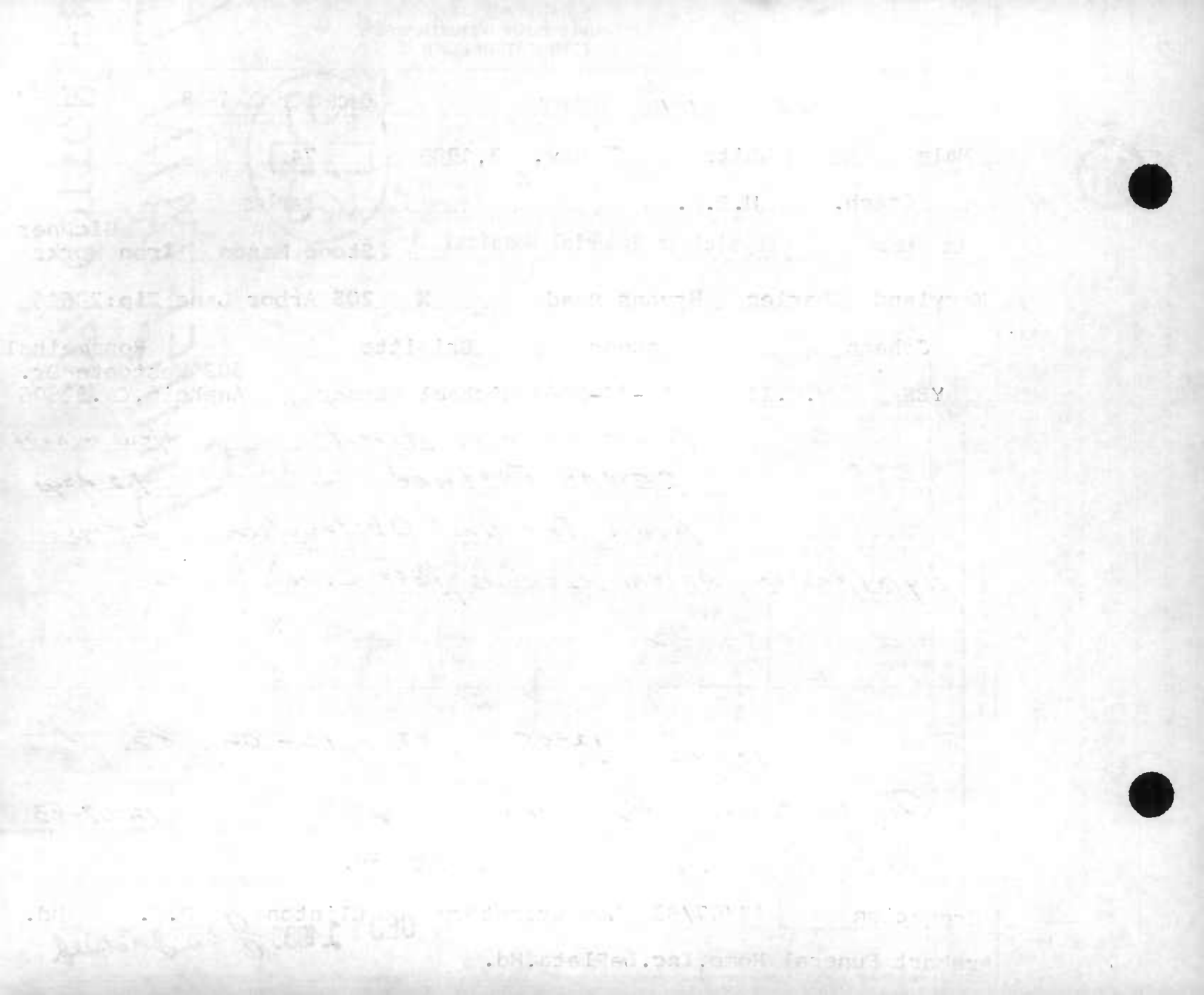
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR
Lorenz N/M/N Wagner						December 6, 1983			10:56 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
Male		White		Nov. 3, 1909		74 YRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Czech.		U.S.A.				Charles MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
La Plata		Physicians Memorial Hospital				Stone Mason		Iron Works	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Maryland Charles Bryans Road					205 Arbor Lane Zip: 20616				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			ADDRESS			
Johann Wagner			Brigitte Rossmeihs			502 Westgate Dr. Anaheim, Ca. 92806			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		
YES			W.W.II		579-54-5469 Michael Wagner		502 Westgate Dr. Anaheim, Ca. 92806		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I: DEATH WAS CAUSED BY:									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) <u>Acute Cardiac Arrest</u>									<u>few minutes</u>
5609 DUE TO, OR AS A CONSEQUENCE OF (b) <u>RENAL FAILURE</u>									<u>1-2 days</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Intestinal Obstruction</u>									<u>2 days</u>
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Hypertension, ARTERIOSCLEROSIS, Post Cerebral Thrombosis</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (If (this hospital) attended the deceased from <u>12-05</u> , 19 <u>83</u> , to <u>12-06</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>12-06</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
Aurelio C. Delapaz			M.D.					12-07-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS						
Aurelio Delapaz, M.D.			La Plata, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Cremation			12/07/83		Lee Crematory		Clinton P.G. Md.		
24. FUNERAL DIRECTOR NAME			25a. ADDRESS			25b. DATE OF RECORD (RECEIVED BY)			
Arehal Funeral Home, Inc.			La Plata, Md.			DEC 11 1983			

BP

DHMH-16 50M 1/81
(VRA 15, 4)



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Cecelia M Warren			2a. DATE OF DEATH MONTH DAY YEAR December 8th, 1983		2b. HOUR 10:10A		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH 7/15/07 YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 76	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D.C.		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH LaPlata		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Physician Memorial		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Charles		13c. CITY OR TOWN Port Tobacco		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS Route 6 20677		14. FATHER'S NAME FIRST MIDDLE LAST William Robertson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta Gordon			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 577-05-3928-D		17. INFORMANT ADDRESS Brenda Warren St. Rt. 1 Box 1145 Port Tobacco Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrest 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 min
(b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF		20 yrs
(c) Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **Type IV HPC, anemia, Hypertension**

19a. TIME OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED n/a		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR n/a 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) n/a		21d. PLACE OF INJURY (AT HOME, STORE, FACTORY, OFFICE, FARM, ETC.) n/a	
21e. INJURY OCCURRED STREET CITY OR TOWN COUNTY STATE n/a		21f. LOCATION STREET CITY OR TOWN COUNTY STATE n/a		21g. LOCATION STREET CITY OR TOWN COUNTY STATE n/a		21h. LOCATION STREET CITY OR TOWN COUNTY STATE n/a	

22a. I certify that (I) (this hospital) attended the deceased from **May 25, 1976** to **Dec 8, 1983**, that (I) (we) last saw the deceased alive on **Nov 2, 1982**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Initials) (did not) view the body after death.

22b. SIGNATURE Charles Pritchett MD		DEGREE		22c. DATE SIGNED Dec 8, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. paul Pritchett		22e. ADDRESS LaFrance Ave. Laplata, Md. 20646			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-14-83		23c. NAME OF CEMETERY OR CREMATORY St. Catherine		23d. LOCATION CITY OR TOWN COUNTY STATE McConchie Charles Md.	
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24. FUNERAL DIRECTOR Thornton Funeral Home		ADDRESS Pomomkey, Md.		25a. DATE REC'D. BY REGISTRAR DEC 12 1983		25b. REGISTRAR'S SIGNATURE John E. Cairns	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



NO

CHIEF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Nettie Pearl Whitson			2a. DATE OF DEATH MONTH DAY YEAR December 3, 1983			2b. HOUR 10:15 A				
3. SEX Female		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR Sept. 6, 1937		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.				
10. CITY OR TOWN OF DEATH White Plains		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NONE IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. #1 Box 587 (Residence)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sectary		12b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		
13a. STATE Maryland			13b. COUNTY Charles		13c. CITY OR TOWN White Plains		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rt. #2 Box 587 20695	
14. FATHER'S NAME FIRST MIDDLE LAST John E. Frazier			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl D. Batchelor							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 243-60-4130		17. INFORMANT ADDRESS Jack J. Whitson same as 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory arrest 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) Cancer of the breast - generalized DUE TO, OR AS A CONSEQUENCE OF (c) metastasis.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (the hospital) attended the deceased from August 21, 1980 to December 1, 1983 , that (I) (we) lost saw the deceased alive on Dec 1st 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.										
22b. SIGNATURE [Signature] M.D.						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-3-83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Annette C. Gonsalves, M.D.						22e. ADDRESS Annapolis Federal Building Waldorf, Maryland 20601				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-6-83		23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Arlington, Arlington, Va.				
24. FUNERAL DIRECTOR NAME ADDRESS Huntt Funeral Home, Waldorf, Maryland						25. DATE RECEIVED BY REGISTRAR REGISTRAR'S SIGNATURE DEC 8 1983 [Signature]				

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RAY VAN UOORHIS WILLSON			2a. DATE OF DEATH MONTH DAY YEAR December 01, 83		2b. HOUR 7:45 M
3. SEX Male	4. RACE Cau-White	5. DATE OF BIRTH MONTH DAY YEAR Sept 16, 1884		6. AGE (IN YEARS LAST BIRTHDAY) 99 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penna	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Charles MD.	
10. CITY OR TOWN OF DEATH La Plata	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PO Box 794 La Plata, Md. 20646		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lumbering		12b. KIND OF BUSINESS OR INDUSTRY Lumber Co
13a. STATE Maryland		13b. COUNTY Charles	13c. CITY OR TOWN La Plata	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Henry Willson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Smith		16. ADDRESS Route 6 La Plata, MD	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 236-12-3852		17. INFORMANT Elizabeth Patricia Runyon	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Irreversible Respiratory Collapse					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2m
DUE TO, OR AS A CONSEQUENCE OF (b) Congestive heart failure					3 days
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Cardiovascular disease					10 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (the hospital) attended the deceased from September 5, 1983 , to December 1, 1983 , that (1) (the) lost saw the deceased alive on December 1, 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Arthur O. Woody MD		DEGREE		22c. DATE SIGNED Dec 01, 1983	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR O. WOODY, M.D.		22e. ADDRESS Box 430 LA PLATA, MD. 20646		22f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 12/05/83	23c. NAME OF CEMETERY OR CREMATORY Trinity Mem. Gds.		23d. LOCATION CITY OR TOWN COUNTY STATE Waldorf Charles Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Arehart Funeral Home, Inc., La Plata, Md.		25. DATE REC'D. BY REGISTRAR DEC 07 1983 REGISTRAR'S SIGNATURE John J. Gass			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PW-1, DETAIL PAGE 5, FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Jennie V. Winters								12		21		19		83		3 ⁰⁰ A M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Fem	BLACK	8 18 18 65 YRS															
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
MARYLAND		UNITED STATES				CHARLES											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
LAPLATA		Physician Memorial Hospital		Baby Sitter		Self Employed											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MARYLAND		CHARLES		La Plata		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Old Washington Road 20646									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
JAMES MATTHEW'S WINTERS		MARY RUSTIN															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
NO		217-24-6893		Hildegard Winters		Box 458 La Plata, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4149 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) <u>Coronary artery disease</u> (c) <u>hypertension</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Congestive heart failure</u>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		M.D.		MEDICAL EXAMINER		DATE SIGNED									
H.M. Mahon-Haft		Charles Co						21 Dec 83									
EXAMINER'S NAME (TYPE OR PRINT)		H.M. Mahon-Haft MD		ADDRESS		SR#1 Box 1020, La Plata, Md 20646											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN											
BURIAL		12-27-83		Sacred Heart		La Plata Charles, MD.											
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
ANTHONY Funeral Home		Pomonkey, Md				DEC 27 1983		John E. Carver									

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